SERIES 1

# UNICARE STATE INDEMNITY PLAN/BASIC

## Benefit Updates and Important Information for Active Employees and Non-Medicare-Eligible Retirees

**Effective February 1, 2010**

UniCare®

Commonwealth of Massachusetts
Group Insurance Commission

## Updates to the UniCare State Indemnity Plan/Basic Member Handbook

This *Benefit Updates and Important Information* booklet ("Benefit Update") contains important updates to your UniCare State Indemnity Plan/Basic coverage with and without CIC (Comprehensive Insurance Coverage), effective February 1, 2010. Please keep this Benefit Update—together with the Series 1 Member Handbook ("Member Handbook") and the 2009 Benefit Update—in a convenient place for easy access when you need to check your health plan information.

This Benefit Update is also available on the Plan's website: visit **www.unicarestateplan.com** > "Members" > "Forms and Documents." The updates in this Benefit Update will also be incorporated into the next printed version of your Member Handbook.

If you have any questions about these changes, please call UniCare Customer Service at (800) 442-9300, Monday through Thursday from 7:30 a.m. to 6:00 p.m. and Friday from 7:30 a.m. to 5:00 p.m. You can also e-mail us from our web site: **www.unicarestateplan.com** (click on "Contact Us"). If you are deaf or hard of hearing and have a TDD machine, contact us on our TDD lines at (800) 322-9161 or (978) 474-5163. A UniCare customer service representative will be happy to help you.

**Note:** Page references in this Benefit Update refer to pages in your Member Handbook unless otherwise indicated.

## Calendar Year Deductible

Beginning February 1, 2010, you must meet a calendar year deductible for most covered services before your health plan begins paying benefits for you or your dependent(s). The calendar year deductible is $250 per member and $750 per family. The calendar year deductible amounts you must satisfy are shown in the chart on page 4 of this Benefit Update.

The following changes are made to your Member Handbook to reflect this change:

A. The "Deductibles" subsection in the "Your Costs" section on page 6 of your Member Handbook is deleted and replaced with the text below. This subsection has been renamed, "Calendar Year Deductible."

**Note:** Information about the inpatient hospital quarterly deductible and the outpatient surgery quarterly deductible is deleted from the "Deductibles" subsection and added to the updated "Copayments" subsection on pages 13-15 of this Benefit Update. These amounts are now referred to as copays rather than deductibles.

### Calendar Year Deductible

The calendar year deductible is a fixed dollar amount you pay for certain services before the Plan begins paying benefits for you or for a covered dependent. The calendar year deductible amounts you must satisfy are shown in the chart on page 4 of this Benefit Update.

**Individual Calendar Year Deductible**
The individual calendar year deductible is the amount you must pay before benefits for many services begin for that calendar year. In addition to meeting the individual calendar year deductible, you continue to be responsible for copays and coinsurance amounts, where applicable. For updated copay amounts, see the chart on page 15 of this Benefit Update.

**Example:** If you go to a provider for a medical problem in January, you will have to pay the applicable copay and then $250 of the Allowed Amount. If your provider charges less than $250, the balance of the deductible will be taken from your next service. If there are remaining charges after the deductible, then, depending on which Basic Plan you have (CIC or without CIC), the Plan pays either 100% of the Allowed Amount, or 80% of the Allowed Amount and you will be responsible for the remaining 20%. Once you have paid the $250 calendar year deductible, you will not have to pay it again for the remainder of the calendar year for any services you receive.

The Plan determines the providers to whom you owe the deductible based on the order in which the claims are submitted. You will receive an Explanation of Benefits (EOB) that will indicate the provider(s) to whom you owe the deductible amounts for any services you receive.

The calendar year deductible applies to most medical services you receive. Check the "Summary of Covered Services" charts on pages 5-12 of this Benefit Update to see the services to which the calendar year deductible applies.

**Family Calendar Year Deductible**
If you have family coverage, a deductible will apply to your family in any calendar year. The family calendar year deductible is a maximum dollar amount your family must pay before benefits for many services begin for that calendar year. In addition to meeting the family calendar year deductible, you and your dependent(s) continue to be responsible for copays and coinsurance amounts, where applicable. For updated copay amounts, see the chart on page 15 of this Benefit Update.

The maximum each person in the family must satisfy is $250 until the family as a whole reaches the $750 maximum.

**Example:** You, your spouse and your three children have family coverage under the Basic plan. You and your three children go to providers for medical care in January. Three of you pay $200 deductibles and one of you pays a $150 deductible. Even though no individual family member has met the $250 deductible, the family deductible of $750 has been met. Therefore, no additional calendar year deductible will apply to your family for that calendar year.

| Calendar Year Deductible | Coverage without CIC (Comprehensive Insurance Coverage) | Coverage with CIC (Comprehensive Insurance Coverage) |
|---|---|---|
| Individual Calendar Year Deductible | $250 per calendar year | $250 per calendar year |
| Family Calendar Year Deductible | $750 per calendar year<br>If you have family coverage, $750 in deductibles will apply to your family in any calendar year. The deductible for any individual family member will not exceed $250. | $750 per calendar year<br>If you have family coverage, $750 in deductibles will apply to your family in any calendar year. The deductible for any individual family member will not exceed $250. |

B. The Summary of Covered Services charts in the "Benefit Highlights" section on pages 26-33 of your Member Handbook and on pages 5-6 of your 2009 Benefit Update are deleted and replaced with the following charts. **Note:** The page references in the third column of these charts refer to pages in your Member Handbook.

## Summary of Covered Services

| | Without CIC | With CIC |
|---|---|---|
| ☎ **Inpatient Hospital Services** in an Acute Medical, Surgical or Rehabilitation Facility | | 📖 Also see page 34 |
| Semi-Private Room, ICU, CCU and Ancillary Services | 100% for the first 120 days in a calendar year after the inpatient hospital quarterly copay and after the calendar year deductible<br>**After 120th Day:** 80% for the remainder of the calendar year | 100% after the inpatient hospital quarterly copay and after the calendar year deductible |
| Medically Necessary Private Room | 100% for the first 90 days in a calendar year after the inpatient hospital quarterly copay and after the calendar year deductible, then 100% at the semi-private level from 91st to 120th day<br>**After 120th Day:** 80% of the semi-private level. The 20% coinsurance amount does not count toward the out-of-pocket maximum. | 100% for the first 90 days in a calendar year after the inpatient hospital quarterly copay and after the calendar year deductible; then 100% at the semi-private level |
| Inpatient Diagnostic Laboratory and Radiology (including high-tech imaging) | 100% after the calendar year deductible | 100% after the calendar year deductible |
| ☎ **Transplant Services** | | 📖 Also see page 41 |
| Quality Centers and Designated Hospitals for Transplants | 100% after the inpatient hospital quarterly copay and after the calendar year deductible | 100% after the inpatient hospital quarterly copay and after the calendar year deductible |
| Other Hospitals | 80% after the inpatient hospital quarterly copay and after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum. | 80% after the inpatient hospital quarterly copay and after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum. |

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the "Managed Care Program" section for specific notification requirements and responsibilities.

For deductible and copay amounts, see the charts on pages 4 and 15 in this Benefit Update. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

## Summary of Covered Services

| | Without CIC | With CIC |
|---|---|---|
| **Other Inpatient Facilities** | | Also see page 34 |
| ▪ Sub-Acute Care Hospitals/Facilities<br>▪ Transitional Care Hospitals/Facilities<br>▪ Long-Term Care Hospitals/Facilities<br>▪ Chronic Disease Hospitals/Facilities<br>▪ Skilled Nursing Facilities | 80% after the calendar year deductible, up to a maximum of 45 days per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum | 80% after the calendar year deductible, up to a maximum of 45 days per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum |
| **Emergency Treatment for an Accident / Sudden Serious Illness** | | Also see page 35 |
| Emergency Room Charge | 100% after the emergency room copay and after the calendar year deductible; copay waived if admitted | 100% after the emergency room copay and after the calendar year deductible; copay waived if admitted |
| Radiology (including high-tech imaging) | 100% after the calendar year deductible | 100% after the calendar year deductible |
| Diagnostic Laboratory Testing | 100% after the calendar year deductible | 100% after the calendar year deductible |
| **Non-Emergency Treatment** | | Also see page 35 |
| Emergency Room Charge | 100% after the emergency room copay and after the calendar year deductible; copay waived if admitted. | 100% after the emergency room copay and after the calendar year deductible; copay waived if admitted. |
| ☎ High-Tech Imaging such as MRIs, CT scans and PET scans | 80% after the copay per scan, and after the calendar year deductible; maximum of one copay per day | 100% after the copay per scan, and after the calendar year deductible; maximum of one copay per day |
| All Other Radiology | 80% after the calendar year deductible | 100% after the calendar year deductible |
| Diagnostic Laboratory Testing | 100% after the calendar year deductible | 100% after the calendar year deductible |

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For deductible and copay amounts, see the charts on pages 4 and 15 in this Benefit Update. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

## Summary of Covered Services

| | Without CIC | With CIC |
|---|---|---|
| **☎ Surgery** | | Also see page 35 |
| Inpatient Surgery | 80% after the calendar year deductible | 100% after the calendar year deductible |
| Outpatient Surgery at a Hospital | 80% after the outpatient surgery quarterly copay and after the calendar year deductible | 100% after the outpatient surgery quarterly copay and after the calendar year deductible |
| Surgery at an Ambulatory Surgical Facility or Physician's Office | 80% after the calendar year deductible | 100% after the calendar year deductible |
| **Outpatient Medical Care** | | Also see pages 36-41 |
| For Services at a Hospital (other than the services listed below) | 100% after the calendar year deductible | 100% after the calendar year deductible |
| Diagnostic Laboratory Testing | 100% after the calendar year deductible | 100% after the calendar year deductible |
| Radiology | | |
| ☎ High-Tech Imaging such as MRIs, CT scans and PET scans | 80% after the copay per scan, and after the calendar year deductible; maximum of one copay per day | 100% after the copay per scan, and after the calendar year deductible; maximum of one copay per day |
| All Other Radiology | 80% after the calendar year deductible | 100% after the calendar year deductible |
| Licensed Retail Medical Clinics at Retail Pharmacies | 80% after the copay | 100% after the copay |
| ☎ Physical Therapy and ☎ Occupational Therapy | 100% after the copay | 100% after the copay |
| Speech Therapy | 80%, up to a maximum benefit of $2,000 per calendar year | 100%, up to a maximum benefit of $2,000 per calendar year |
| Chemotherapy | 80% after the calendar year deductible | 100% after the calendar year deductible |

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For deductible and copay amounts, see the charts on pages 4 and 15 of this Benefit Update. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

## Summary of Covered Services

| | Without CIC | With CIC |
|---|---|---|
| **Physician Services** | | Also see page 39 |
| Non-Emergency Treatment at Home, Office or Outpatient Hospital | 80% after the applicable office visit copay | 100% after the applicable office visit copay |
| Hospital Inpatient | 80% after the calendar year deductible | 100% after the calendar year deductible |
| Emergency Treatment | 80% after the calendar year deductible | 100% after the calendar year deductible |
| ☎ Chiropractic Care or Treatment | 80% after the chiropractic visit copay; maximum benefit of $40 per visit, 20 visits per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum. | 80% after the chiropractic visit copay; maximum benefit of $40 per visit, 20 visits per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum. |
| ☎ **Private Duty Nursing** | | Also see page 40 |
| Provided in a Home Setting Only | 80% after the calendar year deductible for a registered nurse, up to a calendar year maximum benefit of $4,000. The 20% coinsurance amount does not count toward the out-of-pocket maximum. | 80% after the calendar year deductible for a registered nurse, up to a calendar year maximum benefit of $8,000. Of this $8,000, up to $4,000 may be for licensed practical nurse services if no registered nurse is available. The 20% coinsurance amount does not count toward the out-of-pocket maximum. |
| ☎ **Home Health Care** | | Also see page 38 |
| Medicare Certified Home Health Agencies and Visiting Nurse Associations[1] | 80% after the calendar year deductible | 80% after the calendar year deductible |

1 A program is available to enhance the benefit for home health care by using designated providers. Check our list of Preferred Vendors at www.unicarestateplan.com > "Find a Provider" > "All Provider Listings" or call the Andover Service Center at (800) 442-9300 for more information.

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the "Managed Care Program" section for specific notification requirements and responsibilities.

For deductible and copay amounts, see the charts on pages 4 and 15 of this Benefit Update. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

## Summary of Covered Services

| | Without CIC | With CIC |
|---|---|---|
| **Home Infusion Therapy** | | Also see page 52 |
| Preferred Vendors[1] | 100% after the calendar year deductible | 100% after the calendar year deductible |
| Other Vendors | 80% after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum. | 80% after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum. |
| **Preventive Care**<br>For information on covered preventive laboratory services and for office visit frequency limits, see pages 39-40 | | Also see pages 39-40 |
| Office Visits | 100% after the applicable office visit copay | 100% after the applicable office visit copay |
| Annual Gynecological Visits | 100% after the applicable office visit copay | 100% after the applicable office visit copay |
| Immunizations | 100% | 100% |
| Colonoscopies[2] | 100% after the outpatient surgery quarterly copay | 100% after the outpatient surgery quarterly copay |
| Mammograms[2] | 100% | 100% |
| Pap Smears[2] | 100% | 100% |
| Bone Density Testing | 100% after the calendar year deductible | 100% after the calendar year deductible |
| Covered Laboratory Testing | 100% after the calendar year deductible | 100% after the calendar year deductible |

1 For a list of the Plan's Preferred Vendors, go to www.unicarestateplan.com > "Find a Provider" > "All Provider Listings" or call the Andover Service Center at (800) 442-9300.

2 Colonoscopies, mammograms and Pap smears are subject to the calendar year deductible when performed as a diagnostic (non-preventive) treatment.

To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the "Managed Care Program" section for specific notification requirements and responsibilities.

For deductible and copay amounts, see the charts on pages 4 and 15 of this Benefit Update. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

## Summary of Covered Services

| | Without CIC | With CIC |
|---|---|---|
| **Hospice** | | Also see page 42 |
| Medicare Certified Hospice | 100% after the calendar year deductible | 100% after the calendar year deductible |
| Bereavement Counseling | 80% after the calendar year deductible, up to a maximum benefit of $1,500 per family. The 20% coinsurance amount does not count toward the out-of-pocket maximum. | 80% after the calendar year deductible, up to a maximum benefit of $1,500 per family. The 20% coinsurance amount does not count toward the out-of-pocket maximum. |
| **Early Intervention Services for Children** | | Also see page 37 |
| Programs Approved by the Department of Public Health | 80% after the calendar year deductible, up to a maximum benefit of $5,200 per child per calendar year, and a lifetime maximum benefit of $15,600. The 20% coinsurance amount does not count toward the out-of-pocket maximum. | 80% after the calendar year deductible, up to a maximum benefit of $5,200 per child per calendar year, and a lifetime maximum benefit of $15,600. The 20% coinsurance amount does not count toward the out-of-pocket maximum. |
| **Ambulance** | | Also see page 36 |
| | 100% of the first $25, then 80% after the calendar year deductible | 100% after the calendar year deductible |
| **Coronary Artery Disease (CAD) Secondary Prevention Program** | | Also see page 23 |
| Designated Programs Available through Medical Case Management | 90% after the calendar year deductible. The 10% coinsurance amount does not count toward the out-of-pocket maximum. | 90% after the calendar year deductible. The 10% coinsurance amount does not count toward the out-of-pocket maximum. |
| All Other Programs | Not covered | Not covered |

For deductible and copay amounts, see the charts on pages 4 and 15 of this Benefit Update. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

## Summary of Covered Services

| | Without CIC | With CIC |
|---|---|---|
| **☎ Durable Medical Equipment (DME)** | | 📖 Also see page 43 |
| Preferred Vendors[1] | 100% after the calendar year deductible | 100% after the calendar year deductible |
| Other Vendors | 80% after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum. | 80% after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum. |
| **Hospital-Based Personal Emergency Response Systems (PERS)** | | 📖 Also see page 42 |
| Installation | 80% after the calendar year deductible, up to a maximum benefit of $50. The 20% coinsurance amount does not count toward the out-of-pocket maximum. | 80% after the calendar year deductible, up to a maximum benefit of $50. The 20% coinsurance amount does not count toward the out-of-pocket maximum. |
| Rental Fee | 80% after the calendar year deductible, up to a maximum benefit of $40 per month. The 20% coinsurance amount does not count toward the out-of-pocket maximum. | 80% after the calendar year deductible, up to a maximum benefit of $40 per month. The 20% coinsurance amount does not count toward the out-of-pocket maximum. |
| **Prostheses[2]** | | 📖 Also see page 40 |
| | 80% after the calendar year deductible | 80% after the calendar year deductible |
| **Braces[3]** | | 📖 Also see page 36 |
| | 80% after the calendar year deductible | 80% after the calendar year deductible |

1 💻 For a list of the Plan's Preferred Vendors, go to www.unicarestateplan.com > "Find a Provider" > "All Provider Listings" or call the Andover Service Center at (800) 442-9300. If an item is not available through a Preferred Vendor and you obtain it from another provider, it will be covered at 80%.

2 Breast prostheses are covered at 100% after the calendar year deductible. Wigs are not subject to the calendar year deductible.

3 Orthopedic shoe(s) with attached brace is covered at 100% after the calendar year deductible.

☎ To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the "Managed Care Program" section for specific notification requirements and responsibilities.

For deductible and copay amounts, see the charts on pages 4 and 15 of this Benefit Update. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

## Summary of Covered Services

| | Without CIC | With CIC |
|---|---|---|
| **Hearing Aids** | | Also see page 38 |
| | 100% of the first $500; then 80% of the next $1,500, up to a maximum benefit of $1,700 every two years. The 20% coinsurance amount does not apply to the out-of-pocket maximum. | 100% of the first $500; then 80% of the next $1,500, up to a maximum benefit of $1,700 every two years. The 20% coinsurance amount does not apply to the out-of-pocket maximum. |
| **Eyeglasses / Contact Lenses** | | Also see page 49 |
| | 80% after the calendar year deductible. Limited to the initial set within six months following cataract surgery | 80% after the calendar year deductible. Limited to the initial set within six months following cataract surgery |
| **Routine Eye Examinations** (including refraction) | | |
| | 100% after the applicable copay. Covered once every 24 months. | 100% after the applicable copay. Covered once every 24 months. |
| **Family Planning Services** | | Also see page 37 |
| Office Visits | 100% after the applicable office visit copay | 100% after the applicable office visit copay |
| Procedures | 100% after the calendar year deductible | 100% after the calendar year deductible |
| **All Other Covered Medical Services** | | Also see pages 36-41 |
| | 80% after the calendar year deductible | 80% after the calendar year deductible |

For deductible and copay amounts, see the charts on pages 4 and 15 of this Benefit Update. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

## Reconsideration Process

The subsection, "Expedited Appeals Process" in the "Managed Care Program" section on page 23 of your Member Handbook is now titled, "Reconsideration Process."

## Copays for Medical Services

### Copay Changes

Beginning February 1, 2010, copays for the following services are changed:

- Physician office visits
- Licensed retail medical clinics at retail pharmacies
- Services provided by nurse practitioners
- Routine eye exams
- Physical therapy and occupational therapy
- Chiropractic care
- Family planning services office visits
- Emergency room charge
- Outpatient surgery
- Outpatient high-tech imaging such as MRIs, CT scans and PET scans

For changes to office visit copays for mental health, substance abuse and Employee Assistance Programs, see page 17 of this Benefit Update

In addition, the inpatient hospital quarterly deductible and outpatient surgery quarterly deductible are now referred to as copays. This change is reflected in your Member Handbook as follows:

- References to these two deductibles have been removed from the "Deductibles" subsection on pages 6-7 in the "Your Costs" section of your Member Handbook, and added to the updated "Copayments" subsection on pages 13-15 of this Benefit Update.
- The following terms are changed as indicated below, wherever they appear in your Member Handbook:
  - "inpatient hospital quarterly deductible" is changed to "inpatient hospital quarterly copay."
  - "outpatient surgery quarterly deductible" is changed to "outpatient surgery quarterly copay."

**The "Copayments" subsection on pages 7-8 in the "Your Costs" section of your Member Handbook and in the copay chart on page 3 of your 2009 Benefit Update are deleted and replaced with the following, to reflect the above copay changes:**

### Copayments

A copayment ("copay") is a fixed dollar amount you pay to a provider at the time of service. Copay amounts vary depending on the type of provider, the type of service you receive and the tier level of the physician or hospital. Copays are always deducted before the individual calendar year deductible is applied (where applicable). Copays do not count toward satisfying the annual calendar year deductible, coinsurance amounts or out-of-pocket maximums. See the copay chart on page 15 of this Benefit Update for copays for each type of service.

**Example:** If you are a member of the UniCare State Indemnity Plan/Basic and you or a covered dependent go to a physician's office, you or your dependent will be responsible for paying an office visit copay. Although you usually pay the copay at the time of the visit, you can also wait until the provider bills you.

Another example of a copay you may owe is the emergency room copay every time you go to the emergency room. This copay is waived if you are admitted to the hospital. However, if you are admitted to the hospital, the inpatient quarterly copay applies.

**Inpatient Hospital Quarterly Copay**
The inpatient hospital quarterly copay applies on a per-person, per-calendar-year-quarter basis. Each time you or a covered dependent is admitted to a hospital, you are responsible for this copay. However, once a covered person pays this copay in any single calendar year quarter, he or she will not have to pay the copay again during that same calendar year quarter. In addition, the inpatient hospital copay is waived for re-admissions that occur within 30 days following a hospital discharge within the same calendar year (even if the admissions occur in different calendar year quarters). This copay does not apply toward the calendar year deductible.

**Example 1:** If you have coverage with CIC and are admitted to the hospital in January and stay overnight, you will be responsible for paying the inpatient hospital copay. If you are re-admitted in March, you will not be responsible for another copay, as March is in the same calendar year quarter as January. However, if you are re-admitted in May you will incur another inpatient hospital copay.

**Example 2:** If you are admitted to the hospital at the end of March and then re-admitted in April (within 30 days of your March discharge), you will not be responsible for another inpatient hospital copay. But if you are re-admitted to a hospital in May (more than 30 days from your March discharge), you will incur another inpatient hospital copay.

**Example 3:** If you are admitted to the hospital at the end of December and then are re-admitted in the beginning of January, you will be responsible for another inpatient hospital copay because the admissions were not in the same calendar year (even though the two admissions occur within 30 days of each other).

**Outpatient Surgery Quarterly Copay**
The outpatient surgery quarterly copay is a per-person, per-calendar-year-quarter copay. Each time you or a covered dependent has surgery at a hospital, you are responsible for paying this copay. However, once a covered person pays the outpatient surgery quarterly copay in any calendar year quarter, he or she will not have to pay this copay again during that same calendar year quarter. This copay does not apply toward the calendar year deductible. (Note: When you have outpatient surgery at a freestanding ambulatory surgical facility or at a physician's office, you do not have to pay the outpatient surgery quarterly copay.)

**Example:** If you have outpatient surgery at a hospital in January, you will be responsible for paying the outpatient surgery copay on the hospital charges. If you have another surgery in March, you will not have to pay another outpatient surgery copay as March is in the same calendar year quarter as January. However, if you have surgery at a hospital in May, you will incur another outpatient surgery copay.

**Copays for Medical Services**
The chart on page 15 of this Benefit Update shows the copays you are responsible for with certain types of medical services. The names of the tiers have been assigned by the GIC for use uniformly across all of its health plans. For information about physician tier designation, see page 4 of your 2009 Benefit Update. (Please note that you are not required to select a primary care physician.)

**You can also use the following providers at the same copay level as Tier 2 physicians:**

- All non-Massachusetts physicians
- Physicians listed in the Massachusetts Physician Tier Listing with the indication that they do not have sufficient data available to allow us to determine any type of scoring—such as those physicians who are new to practice
- Nurse practitioners and physician assistants

## Copays for Medical Services

| Type of Medical Visit | Without CIC | With CIC |
|---|---|---|
| ☎ Inpatient Hospital Services | $300. Inpatient hospital quarterly copay waived for re-admission within 30 days of a hospital discharge, within the same calendar year. | $200. Inpatient hospital quarterly copay waived for re-admission within 30 days of a hospital discharge, within the same calendar year. |
| ☎ Outpatient Surgery | $110 per quarter | $110 per quarter |
| Emergency Room Charge | $100 (waived if admitted) | $100 (waived if admitted) |
| ☎ Outpatient High-Tech Imaging (such as MRIs, CT scans and PET scans) at Hospital and Non-Hospital Locations | $100 per scan; maximum of one copay per day | $100 per scan; maximum of one copay per day |
| Physician Office Visits | | |
| **Tier 1*** (excellent):** | | |
| Primary care physician[1] | $15 | $15 |
| Specialty care physician | $20 | $20 |
| **Tier 2** (good):** | | |
| Primary care physician[1] | $30 | $30 |
| Specialty care physician | $30 | $30 |
| **Tier 3* (standard):** | | |
| Primary care physician[1] | $35 | $35 |
| Specialty care physician | $40 | $40 |
| Services Provided by Nurse Practitioners | $30 | $30 |
| ☎ Physical Therapy and Occupational Therapy | $20 | $20 |
| ☎ Chiropractic Care | $20 | $20 |
| Routine Eye Examinations: | | |
| With an Optometrist | $30 | $30 |
| With an Ophthalmologist | See specialty care physician office visit copays above | See specialty care physician office visit copays above |
| Licensed Retail Medical Clinics at Retail Pharmacies | $20 | $20 |

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1 Primary care physicians are pediatricians, and physicians specializing in family medicine, general medicine and/or internal medicine. Some primary care physicians may also be specialty care physicians and, if so, may be considered to be specialists in the determination of their tier and copay assignments. This means you will pay the office visit copay for the type of practice the physician has been designated to, regardless of whether you see the physician for a primary care or specialty care visit.

## Online Plan Resources

### Online Access to Medical Information and Plan Resources at www.unicarestateplan.com

The Healthcare Advisor™, a hospital comparison resource, is no longer available at **www.unicarestateplan.com**. To reflect this change to your Member Handbook, the bulleted item titled, "Get help from the Healthcare Advisor™" under the subheading, "Online Access to Medical Information and Plan Resources at **www.unicarestateplan.com**" on page 3 of your Member Handbook has been deleted. See our link to other hospital comparison resources on our "Health Care Quality Initiatives" page at **www.unicarestateplan.com**.

## United Behavioral Health

### Mental Health, Substance Abuse and Enrollee Assistance Programs—Effective February 1, 2010

Effective February 1, 2010, there will be changes to your copays for outpatient mental health, substance abuse and Enrollee Assistance Program (EAP) visits. The benefits charts on page 85 of your Member Handbook and on page 28 of your Benefit Update are deleted and replaced with the following to reflect this change:

| Covered Services | Network Benefits | Out-of-Network Benefits |
|---|---|---|
| **Outpatient Care (e, f) – Mental Health, Substance Abuse and Enrollee Assistance Program (EAP)** | | |
| Enrollee Assistance Program (EAP) | Up to 3 visits: 100% | No coverage for EAP |
| | EAP *non-notification penalty* reduces benefit to zero: no benefits paid. | |
| Individual and family therapy | 100%, after $20 per visit | First 15 visits: 80% of *allowed charges* (e, f)<br>Visits 16 and over: 50% of *allowed charges* (e, g) |
| Group therapy | 100%, after $15 per visit | First 15 visits: 80% of *allowed charges* (e, f)<br>Visits 16 and over: 50% of *allowed charges* (e, g) |
| Medication Management (15-30 minute psychiatrist visit) | 100%, after $15 per visit | First 15 visits: 80% of *allowed charges* (e, f)<br>Visits 16 and over: 50% of *allowed charges* (e, f) |
| In-Home Mental Health Care | Full coverage | First 15 visits: 80% of *allowed charges* (e, f)<br>Visits 16 and over: 50% of *allowed charges* (e, f) |
| Drug Testing (as an adjunct to Substance Abuse treatment) | Full coverage | No coverage |
| | *Non-notification penalty* reduces benefit to zero: no benefits paid. | |
| Provider Eligibility – Provider must be licensed in one of these disciplines. | MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS, MA (g) | MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS, MA (g) |

(a) Separate from medical *deductible* and medical *out-of-pocket maximum*. *Network* and *out-of-network out-of-pocket maximums* do not *cross accumulate*.
(b) *Cross accumulates* with all *out-of-network* mental health and substance abuse benefit levels.
(c) Waived if readmitted within 30 days: maximum one *deductible* per calendar quarter.
(d) Out-of-network care that is not preauthorized is subject to financial penalty and retrospective review.
(e) All care requires preauthorization.
(f) All *out-of-network* visits in a given calendar year are accumulated to determine the appropriate *out-of-network* level of reimbursement.
(g) Massachusetts independently licensed providers: psychiatrists, psychologists, licensed clinical social workers, psychiatric nurse clinical specialists and allied mental health professionals.

Please note: The words in italics have special meanings that are given in the Glossary section in Part II on pages 81-82 of your Member Handbook.

## Notes

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